THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 15 2006

The Honorable John D. Dingell
House of Representatives
Washington, DC 20515-6115

Dear Mr. Dingell:

Thank you for your letter concerning the ongoing challenges the Nation faces in rebuilding New Orleans' healthcare infrastructure, which was devastated by Hurricane Katrina in August 2005. The Department of Health and Human Services stands firm in its commitment to do its part in revitalizing the Gulf Coast region and City of New Orleans. The health and welfare of the residents located in the affected regions are of paramount concern, and many steps have been taken to restore the health care system that serves them.

Providing medical care is one of the most daunting challenges for New Orleans as it rebuilds, and we are dedicated to ensuring that it can adequately care for its residents. I assure you that the Department's efforts to respond to this devastating event are being coordinated with the utmost concern for the region's needs.

I have enclosed specific answers to the questions you raised. Please call me if you have any questions or concerns. I will also provide this response to the cosigners of your letter.

Sincerely,

Michael O. Leavitt

Enclosure

1. A written strategic plan developed by HHS for the restoration of healthcare services in the Gulf Coast region would focus the Federal response more effectively. It should include (a) the priorities of where hurricane relief monies for healthcare restoration should be spent, the source of those funds, and detailed reasons for such expenditures; (b) a listing of health care services and institutions that should be restored or rebuilt; (c) a schedule for restoration. Has HHS or any other agency developed such a plan? If yes, please attach a copy and include the names of HHS officials responsible for carrying out such a plan. If not, please describe any other strategic planning.

The Gulf's health infrastructure of delivery systems, staffing, and access to care needed by its citizenry, has evolved in ways unique to the culture and history of each community affected by Katrina and Rita. The various State and local governments through their licensing and funding authorities are intimately familiar with the location, operational capacity and ongoing status of their own health care infrastructures. Over the past few months, local and state officials, providers, and other stakeholders have formed several planning coalitions expressing various visions and early ideas for how to rebuild the Gulf States with a new healthier future.

The role of the Federal Government should be to support these existing mechanisms, offering expertise, when needed or desired, and taking action wherever possible to eliminate unnecessary impediments to rebuilding health infrastructure. Aid should be delivered, to the maximum extent possible, through existing State and local governments, rather than through the creation of new Federal institutions or programs. Successful solutions will be based on locally led and community-based collaborative efforts. HHS is working with private/public sector individuals in both Louisiana and Mississippi to identify short and long- term needs and to assist in addressing them.

As discussed in question 2 below, the Federal Government has many significant programs that pay for care provided to individuals who evacuated because of the hurricanes. Other existing Federal Government programs support rebuilding the healthcare infrastructure.

HHS has developed Guiding Principles to provide a framework within which the states and communities can consider how best to utilize these existing programs. Our key principles for rebuilding Louisiana's healthcare infrastructure include: (see also attachment A)

(1) Assist Local Private Sector Efforts/Coordinate between Local, State and Federal Governments

- Support existing, locally led, community–based mechanisms, offering expertise, when needed or desired, and taking action wherever possible to eliminate unnecessary impediments to rebuilding health infrastructure.
- Deliver aid, to the maximum extent possible, through existing State and local governments, rather than through the creation of new Federal institutions or programs.

(2) Support Ambulatory and Community-Based Services:

- Avoid investing in the rebuilding of ineffective services and systems destroyed by Hurricanes

Katrina and Rita,

- Support strategies that strive to rebalance care toward ambulatory and community-based services rather than emergency rooms and institutionally based care, while providing efficient, effective care delivery for all residents

(3) Provide Higher Quality Care and Preventive Services:

- Lend support to efforts that make the system more prevention oriented, advance the quality and value of health care, cultivate promising, evidence-based patient care improvements, and reward quality outcomes.
- This type of continuous quality management will offer the best possible *return on investment* for payers, providers, consumers and the public

(4) Support Integrated Efforts to Improve Quality:

- Encourage local communities to improve the quality and safety of health services by greater reliance on and sharing of electronic health information technology
- Electronic record systems, emails, telemedicine, and other innovative approaches can help patients not only avoid costly complications, but perhaps even avoid the need for unnecessary health services.

(5) Support Personal Responsibility and Control:

- Support the self-determination of evacuees, since individuals and families focusing on their own needs, resources and interests are far more likely to reach and/or obtain favorable results for themselves and for the broader society than when government restricts or directs their choices.
- To help people take more control of their health care, new initiatives should pay particular attention to supporting individuals directly, rather than institutions.

(6) Encourage Emergency Preparedness:

- To mitigate the risk of future loss of life or liberty when necessary to achieve the common good, support incorporating into the health care delivery system an all hazards approach for effective emergency preparedness for hospitals and other health care providers.

2. Has HHS established a task force to coordinate its response to the destruction of healthcare facilities and systems on the Gulf Coast resulting from Hurricanes Katrina, Rita, and Wilma? If so, please list the purpose of the task force, its members, and their respective responsibilities. If not, please describe how the Department is coordinating the response among its various offices and other government agencies and attach any relevant documentation.

Yes. Shortly after Hurricane Katrina hit, the White House formed several working groups related to restoration of the Gulf Coast, one of which was called "Health Care: Chronic Care and Facilities Restoration Workgroup". The original members were composed of HHS' senior leadership, and also included representatives from the Veteran's Administration and the Department of Homeland Security. The list of representatives included:

Alex Azar (Department of Health and Human Services (DHHS)) – Chairman

Tom Barker (HHS)
Christina Beato (HHS)
Craig Burton (HHS)
Richard Carmona (HHS)
Carolyn Clancy (Agency for Healthcare Research and Quality (AHRQ))
Charles Curie (Substance Abuse and Mental Health Services Administration (SAMHSA))
Betty Duke (Health Resources and Services Administration (HRSA))
Diane Faup (HHS)
Julie Goon (Centers for Medicare and Medicaid Services (CMS))
Herb Kuhn (CMS)
Mark McClellan (CMS)
Leslie Norwalk (CMS)
Paula Stannard (HHS)
William Vanderwagen (IHS)
Stewart Simonson (Office of Public Health and Emergency Preparedness (OPHEP))
Gerald Parker (OPHEP)

Mike Kussman (Department of Veterans Administration (VA))
Jeff Runge (Department of Homeland Security (DHS))

The group produced two major working papers. The first is called "Summary of Federal Payments Available for Providing Health Care Services to Hurricane Evacuees and Rebuilding Health Care Infrastructure", which was posted originally on HHS' website at http://www.hhs.gov/katrina/fedpayment.html#2#2 during October 2005 and continues to be updated as new information is learned. This funding resource document has since served as the basis for two major all-day interagency workshops sponsored by HHS and the State of Louisiana held in New Orleans on January 10 and February 9, 2006, called "Federal Funding Assistance for Community Health and Medical Recovery: A Workshop for Creating Local Partnerships". The primary audience for the workshops was local and regional health care providers and elected officials, particularly in the few remaining parishes where the Federal Government is still the primary health care presence.

The second major paper describes the Guiding Principles for "Rebuilding the Healthcare Infrastructure in the Gulf States" that are set forth above. While this group has disbanded, many members are included in meetings of the interagency task force described in the answer to question 3.

3. Is there an interagency task force in place that has as one of its responsibilities coordination of the restoration of the healthcare system along the Gulf Coast? If yes, please describe the task force, list the HHS representatives, and attach any relevant documentation. If the answer is no, please discuss in detail how the Federal Response is coordinated.

Yes. Currently, the Gulf Coast Recovery Working Group is being led day to day by Leslie Norwalk, Deputy Administrator of CMS with an HHS staff level group representing the leadership of the Office of the Secretary, CMS, HRSA, SAMHSA, PHS and ACF. The group meets regularly to resolve issues and offer advice on how to make HHS' programs better support the Gulf health care recovery effort. The group coordinates its Federal efforts operationally as part of the National Response Plan's Emergency Support Function (ESF-14), which is responsible for the long term recovery of the area, and on a policy level, through the Office of the Federal Coordinator of Gulf Coast Recovery, led by Chairman Don Powell. Additionally, the working group continues to coordinate its efforts with the State and local leadership associated with the Louisiana Recovery Authority - Health Task Force, the Bring New Orleans Back Commission, and Governor Barbour's Commission on Recovery, Rebuilding and Renewal.

4. Under its Public Assistance program, FEMA is responsible for providing 75 percent of the funds to rebuild public facilities, such as hospitals and community health centers, damaged or destroyed by natural disasters. Five hospitals- three of which are public facilities- and several community healthcare centers were destroyed or severely damaged by Hurricane Katrina. At least one was damaged by Hurricane Rita. In previous disasters, FEMA has not provided funds to rebuild healthcare facilities in a timely manner. Has HHS been briefed regularly by FEMA concerning the status of the reimbursement? Has HHS taken any steps to encourage and facilitate timely payments by FEMA?

The HHS Secretary's Emergency Response Team (SERT) is in direct communication with the FEMA Public Assistance (FEMA PA) representatives at the Joint Field Office in Baton Rouge and the Area Field Office in New Orleans.

HHS' Office of Public Health and Emergency Preparedness (HHS/OPHEP) coordinated through the Secretary's Emergency Response Team the January 10 workshop described above in the answer to Question #2. Representatives from various HHS agencies and operating divisions and other Federal agencies and departments presented to parish representatives the opportunities for funding long term recovery. FEMA PA was represented at this workshop.

5. The current Federal cost share under the FEMA Public Assistance Grant Program is 75 percent, which can be increased in catastrophic disasters. Hurricane Katrina has been classified as an "incident of national significance," or a catastrophic disaster. Has HHS taken any steps to evaluate whether the Federal share should be increased for these facilities? If so, please describe them. If not, please explain why not.

FEMA Public Assistance officials have reported to HHS that currently at least the Federal match has been raised for the repair or replacement of qualifying damaged Hospitals from 75% to 90%, and the Federal match for temporary structures (e.g., trailers) that can be used by qualifying health care entities has been raised to 100%.

6. FEMA has the authority to provide emergency shelter for medical personnel on the basis that medical care is an "essential community service," HHS has reported that its Public Health Service team in New Orleans is "working on" housing for healthcare workers. However, USA Today recently reported that New Orleans area hospitals were "in desperate need of staff," mainly because there was no housing for staff ("Gulf Region's Hospitals Struggling after Katrina," USA Today, Dec. 5, 2005). What steps is HHS taking to encourage FEMA to respond in a timely manner to these medical needs?

HHS has worked in conjunction with FEMA to ensure emergency shelter for medical personnel, as such needs have been identified. During the last visit by the Secretary to New Orleans on January 11, the Secretary asked Senior health care officials for Louisiana and for New Orleans to please identify what were the state's most imminent immediate needs requiring action or resolution before focusing on long term infrastructure rebuilding. Such emergency sheltering needs were not identified as a current need.

7. Was HHS consulted on FEMA's recent decision to deny a community development grant to Louisiana State University to assist in keeping Charity viable until new facilities could be obtained?

No - HHS is not aware of any advance consultation from FEMA or other Federal agencies related to the decision to deny the community development block grant (CDBG) related to Charity.

8. In a document presented to staff by Leslie Norwalk, Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS) on November 29, it is reported that medical care for seniors, persons with disabilities, limited-income families, and children is "being addressed". Please explain what steps have been taken to address this need and if new legislative authority is needed.

On September 1, 2005, I exercised my waiver authority under Section 1135 of the Social Security Act. Under this provision, I can waive or modify certain Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) requirements during emergencies to ensure that sufficient health care items and services are available to meet the needs of Medicare, Medicaid and SCHIP beneficiaries and that health care providers that furnish such items and services in good faith may be reimbursed for them. On Wednesday August 31, 2005, I notified the Congress that I was invoking this authority, as a consequence of Hurricane Katrina, in order to protect the health and welfare of the public in areas impacted by this crisis.

To ensure that Medicaid and SCHIP beneficiaries would receive necessary services, HHS/CMS took action under section 1115 waiver authority to provide flexibility and to effectuate the section 1135 waivers through demonstration programs. Specifically, on September 16, 2005, HHS/CMS released a State Medicaid Director's letter and a Multi-State Section 1115 Demonstration Application Template to Provide Medicaid and SCHIP for Evacuees of Hurricane Katrina. Under these demonstrations, eligible evacuees displaced from their homes would be able to enroll to receive services under the Medicaid or SCHIP programs in the State where they

are located.

HHS established a staff team to provide expedited review and approval of these demonstrations so that care can quickly be provided to victims of Hurricane Katrina. These demonstrations permit evacuees to register for Medicaid or SCHIP without many of the traditional administrative requirements for verification and enrollment. In addition, States can extend the expedited application process to evacuees who may be newly eligible because of new economic circumstances created by the hurricane (i.e., loss of job and income or resources that may have made them ineligible prior to the storm.)

Approved demonstrations grant States the authority to provide a period of temporary eligibility for up to 5 months and evacuees will apply through a simplified application within the Host State through January 31, 2006. States may use a simplified income eligibility chart to capture seniors, persons with disability, limited-income families and children who become eligible for services. Applicants may provide self-declaration of information needed for an eligibility determination if the individual is unable to produce necessary verification. This self-declaration can include attestations regarding displacement, income, residency, resources, and immigration status if the evacuee is unable to provide documentation.

In announcing the State Medicaid Director's letter and a Multi-State Section 1115 Demonstration Application Template to Provide Medicaid and SCHIP for Evacuees of Hurricane Katrina, HHS participated in multiple conference calls that were open to all 50 states and the territories to discuss waiver options and answer questions from states. Since then, HHS has participated in numerous conference calls with the National Association of State Medicaid Directors, SAMSHA, HRSA, mental health and substance abuse and long-term care advocacy community groups.

The demonstration process was an immediate approach to providing states with necessary flexibility to address the emergency situation. Prompt and open communication between State Medicaid Directors and HHS ensured an optimal result. If not for the demonstration authority, the lack of flexibility allowed by the Medicaid statute and SCHIP statutes would have prevented States from providing health care coverage immediately to evacuees.

In addition, Section 6201 of the Deficit Reduction Act of 2005 appropriated $2 billion for the health care needs of areas affected by Hurricane Katrina.

9. The health care of the survivors and the existing Medicaid recipients are in jeopardy as long as Louisiana's tax base is in jeopardy. In the House reconciliation bill, there is a provision that would address this issue by providing a 100 percent federal match for all of Louisiana's Medicaid population as well as for evacuees who have been reallocated to other states. Please explain why the Administration is not supporting this bipartisan effort.

The Administration believes that the needs of States can be met without setting the precedent of guaranteeing 100 percent Federal medical assistance percentage (FMAP). Our approach provides targeted relief for the additional State costs to assist Katrina evacuees (over and above ordinary Medicaid costs). For evacuees who are eligible in their Home State but served in a Host State, CMS has entered into Memoranda of Understanding with Home States that recognized their responsibility for the non-Federal share of serving their residents. Host States would be reimbursed for the full cost of serving these evacuees through the combination of the current FMAP and the Home state payment of the non- federal share.

Under the section 1115 demonstration projects, CMS has authorized special pools to help pay for uncompensated costs for services to evacuees that are not covered through these regular Medicaid and SCHIP expenditures. We are pleased that the Deficit Reduction Act of 2005 (DRA) adopted an approach that builds on the approved Section 1115 Hurricane Katrina demonstrations and enables the Administration to respond to the needs of the Katrina survivors and the areas devastated by this natural disaster in an immediate and effective manner. The DRA appropriates $2 billion for payments by the Secretary to eligible States for health care needs of areas affected by Hurricane Katrina.

Under the approved demonstrations, Host States are providing temporary enrollment in their Medicaid or SCHIP programs to evacuees who are parents, pregnant women, children under age 19, individuals with disabilities, low income Medicare recipients, and low income individuals in need of long-term care up to specified income levels. In addition, under the demonstration, normal documentation requirements for verification of Medicaid and SCHIP eligibility, including residency requirements, may be waived. Evacuee status can be established by self-attestation of displacement, resources, income and immigration status, but evacuees will be required to cooperate in demonstrating evacuee and eligibility status.

10. The Administration has said that it is using FEMA funds to help States set up uncompensated care pools. Please list the states and the amount of funds that have been committed for this purpose. If a State does not have an uncompensated care pool, how does it reimburse providers for giving medically necessary services and supplies for Katrina evacuees who have no other coverage for such services?

Eight States have been approved to set up uncompensated care pools. They are: Texas, Alabama, Mississippi, Arizona, Georgia, Tennessee, South Carolina, and Louisiana. The reporting mechanisms are in place and the States can submit such claims at any point. An estimated $30 million transferred from FEMA under the National Disaster Medical System (NDMS) will be available for payment of uncompensated care pool costs. In addition, the Deficit Reduction Act of 2005 appropriates $2 billion for payments by the Secretary to eligible states for health care

needs of areas affected by Hurricane Katrina. One of the purposes of these funds is for total uncompensated care costs under a Hurricane Katrina section 1115 waiver for evacuees and in-state individuals who do not have any other source of health coverage, as well as total costs of uncompensated care for services not covered by the state Medicaid plan for evacuees and in-state individuals receiving temporary eligibility under a waiver.

Those States which do not have approval for uncompensated care pools have indicated to us that they have very little in the way of uncompensated care for evacuees. Any remaining uncompensated care would be paid for through the normal uncompensated care mechanisms such as disproportionate share hospital payments.

11. Please list all of the additional grants and other assistance provided to physicians willing to provide services in areas designated as Health Professional Shortage Areas that were also affected by Hurricanes Katrina, Rita and/or Wilma. Describe any outreach done to providers, local and State governments to make them aware of programs for the affected States.

The vast majority of the hurricane-affected States are already designated as Health Professional Shortage Areas (HPSAs). All applications received from the affected States were reviewed within 48 hours and the normal 30-day comment period was waived. No additional designation action is needed to cover the affected areas and no application submitted from the affected areas has been rejected for designation.

National Health Service Corps clinicians and J1 Visa Waiver physicians are available to serve the affected States and a 10 percent Medicare Bonus payment is available for primary care physicians providing service in the affected areas. Also, Federally Qualified Health Centers (FQHC) and FQHC Look-a-Likes located in the affected areas are automatically HPSAs. The Health Resources and Services Administration (HRSA) has provided technical assistance for the HPSA applications, and answering questions on HPSA scores for National Health Service Corps placements.

HRSA had weekly conference calls with the State Primary Care Offices and State Primary Care Associations from the affected States from September to November 2005 to discuss hurricane relief questions. HRSA also worked closely with State Primary Care Associations on numerous activities to assist health centers during the aftermath of the hurricanes. These activities included: serving as the first line of communication to HRSA about the status of health centers in their States, including daily and weekly reporting on issues experienced by grantees in the field; providing information on facility damage and general needs assessments including technical assistance to the affected health centers; serving as the conduit for health centers for FEMA information and assisting health centers with the application process; assisting health centers with Medicaid reimbursement issues; in some cases, serving as the medical supply and vaccine repository and distribution center for health centers; assisting in the coordination of resources from HHS to respective health centers; working with State Primary Care Offices to expedite HPSA designations in affected States; and working with State Medical Boards to grant temporary licensure for out of State clinicians.

This year's Department of Defense Appropriations Act included $550 million in Social Services Block Grant (SSBG) hurricane relief funds, which were awarded to States on February 8, 2006. These funds may be used to help key providers meet salary and other costs associated with resuming or restoring health services. Additionally, these funds will support States in providing health (including mental health) and human services to meet the needs of affected individuals, particularly those who lack health insurance or adequate access to care. These funds may also support community health care safety net providers to restore and resume their operations.

12. Please list all of the State hospital preparedness grants issued by the Health Resources and Services Administration to address needs resulting from Hurricanes Katrina, Rita and/or Wilma and the purpose of the grant.

The Health Resources and Services Administration's (HRSA) National Bioterrorism Hospital Preparedness Program provided technical assistance to all States on the allowable uses of their existing grant funds for hurricane response activities. HRSA did not have funding to provide grants in response to Hurricane Katrina and the other hurricanes that impacted the Gulf region. Funds could be expended to address hurricane related needs as long as the expenditures were consistent with the purpose of the legislation including purchasing and re-supplying medical and communications equipment, medical supplies, pharmaceuticals, beds, etc; address the health security needs of children and other vulnerable populations; and prepare a plan for triage and transport management. Specifically, the programs funds made it possible for mobile medical units from Nevada and North Carolina to be deployed in response to the hurricanes.

In addition, HRSA's Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program generated a contract to provide to 21 States "as-needed" assistance in the registration, credential verification, and deployment of volunteer medical and healthcare professionals to the Gulf region. Through the contract, the ESAR-VHP program took several specific actions to facilitate these deployments. These included: first, the development of a temporary on-line registration and credential verification system used by seven States that had not yet started developing their ESAR-VHP systems; second, the successful negotiation with major physician and nurse credentialing organizations for free verification of volunteer credentials for the duration of the emergency; and third, assistance to States in working with their State emergency management agency to deploy health and medical personnel through the Emergency Management Assistance Compact in compliance with the National Response Plan. Based on preliminary figures, these 21 States reported sending over 8,300 pre-credentialed volunteer medical and healthcare providers to assist in the Katrina response.

13. Please list all of the Crisis Counseling Assistance and Training Program grants for outreach and crisis counseling that were issued by FEMA and being monitored by the Substance Abuse and Mental Health Services Administration to address evacuee needs resulting from Hurricanes Katrina, Rita and/or Wilma and the purpose of each of the grants.

Immediate Services Program - FEMA Funding: funds available for crisis counseling

Alabama	$1,564,109
Arkansas	$ 349,000
Arizona	$ 187,336
California	$1,003,983
Colorado	$ 348,333
DC	$ 47,184
Florida	$3,309,713
Georgia	$ 870,404
Iowa	$ 102,092
Illinois	$ 368,105
Indiana	$ 192,553
Louisiana	$6,790,608
Maryland	$ 111,499
Missouri	$ 542,250
Mississippi	$4,533,034
Nebraska	$ 46,789
New Jersey	$ 164,654
Nevada	$ 183,892
Ohio	$ 58,059
Oklahoma	$ 365,568
Pennsylvania	$ 261,270
Rhode Island	$ 36,910
Tennessee	$ 127,584
Texas	$3,650,742
Utah	$ 103,804
Washington	$ 128,968
Wisconsin	$ 110,233
West Virginia	$ 45,791

Regular Service Program - FEMA - Crisis Counseling

Twenty-one States applied for Regular Service Grants for Crisis Counseling. The applications have been reviewed but FEMA indicates that the awards will not go out until March.

In addition to the FEMA- funded Crisis Counseling program (CCP), SAMHSA also funds the SAMHSA Emergency Response Grant program. This program is designed to be responsive to State-identified needs. After Hurricane Katrina, grants were awarded as follows:

- Alabama ($100,000) to create a pool of funding to support clinical assessments and immediate direct services.
- Louisiana ($200,000) to focus on the mental health needs of first responders.
- Mississippi ($150,000) to respond to the mental health needs of individuals in mental health treatment facilities in the southern section of the State.
- Texas ($150,000) to support the provisions of methadone medications and related activities for this population.

14. Please list all of the applications from provider hospitals that the CMS has received under the Medicare Extraordinary Circumstances Exception provision resulting from Hurricanes Katrina, Rita and/or Wilma, and that status of each of those applications.

CMS has not received any requests under the Medicare Extraordinary Circumstances Exception under 42 CFR, section 412.348(f). CMS has not receive any applications, however one request for information on this provision was just received from Louisiana.

15. Charity Hospital needs a waiver from CMS to bill for the services that it is providing in its tent facilities. What is the status of this waiver and any other CMS waiver of requirements that would be necessary for payment?

In October 2005, CMS' Dallas Regional Office (RO) and State Survey Agency staff visited the soft-side emergency clinic that LSU Charity opened. At that time, HHS advised hospital representatives that when the hospital wanted to begin operation and have the services considered as part of its current Medicare certification, they should contact the State Survey Agency. The State Survey Agency would conduct a visit to determine if the temporary facility met health and safety expectations. In November, the Chief Executive Officer notified the State Survey Agency about some of its proposed plans, including operation of an Emergency Services Unit (ESU) in Hall J of the New Orleans Convention Center. The State Survey Agency asked the RO to clarify the requirements related to Medicare certification and reimbursement for these freestanding emergency services. On December 21, 2005, CMS' Central Office (CO) and RO staff held a conference call with the Joint Commission for Accreditation of Health Care Organizations (JCAHO). JCAHO staff advised that they visited the ESU and believe it could be included part of the hospital's existing accreditation. Based on the reports from both the State of Louisiana and the JCAHO, who conducted visits of the site, and JCAHO's continued accreditation of Charity Hospital, Medicare billing for services provided continues. CMS CO staff will continue to coordinate weekly calls with JCAHO, the State Survey Agency, and the RO to ensure that required surveys and inspections are made as expeditiously as possible.

On February 3, 2006, CMS Deputy Administrator Leslie Norwalk, who I have designated as HHS Health Recovery Official, corresponded with Dr. Dwayne Thomas, Chief Executive Officer, Louisiana State University, Health Sciences Center, about eligibility for billing for

outpatient and emergency services provided. (See Attachment B.)

16. Charity Hospital is negotiating with Oschner Hospital to lease some facilities for a small level 1 trauma center. Is HHS working with Charity to facilitate the accreditation of this center and its ability to bill patients and obtain Medicare and Medicaid reimbursement? Please describe the steps HHS is taking, if any.

To HHS' knowledge, LSU Charity Hospital and Oschner are continuing to negotiate the terms of the proposed lease agreement that would permit LSU to establish and operate a small Level 1 trauma center at the Elmwood campus of Oschner. HHS is supportive of this concept and will work with the State and both hospitals to ensure the project is implemented in accordance with Medicare and Medicaid laws and regulations.

During weekly conference calls with the CMS RO, JCAHO and Louisiana State Survey Agency, the status of Charity Hospital and its reopening is a standing agenda item. CMS, JCAHO and the Louisiana State Survey Agency will continue to work together to assist Charity and other hospitals in the region as they continue efforts to resume operations and provide much needed health care services to individuals in the region.

17. Before Hurricane Katrina, Charity Hospital operated a Level I trauma center that served nine parishes in New Orleans and parts of Mississippi. What is the position of HHS and/or the Administration as to whether and when this capability should be restored? What steps is HHS taking to restore this capability? Has HHS and/or FEMA undertaken any action to establish a temporary Level I trauma facility staffed by the Public Health Service or other volunteer medical staff such as those serving as part of the National Disaster Medical System?

HHS has responded promptly to all inquiries that have come to its attention related to LSU Charity leasing space to operate such a center. HHS committed to continuing this level of expedited service to ensure that these trauma capabilities are made available as soon as possible and that Medicare and Medicaid provide reimbursement as appropriate.

Under the National Response Plan for addressing federally declared disasters, HHS coordinates the multi-agency Emergency Support Function relating to health and medical needs; this coordination function is known as ESF#8. HHS was responsible for deploying two temporary Level II trauma facilities. To be specific, HHS dispatched a Department of Defense Combat Support Hospital into the area affected by Katrina. This Combat Support Hospital, which operates as a Level II trauma center, was operational at the New Orleans Convention Center until mid-November. In addition, the US Navy Ship Comfort, which also has Level II trauma center capability, was sent to New Orleans but was not utilized. East and West Jefferson Hospitals in the Greater New Orleans Area are now open and operational at the Level II trauma center level.

Rebuilding the Healthcare Infrastructure in the Gulf States

The Department of Health and Human Services' overall vision for recovery and rebuilding in the Gulf States after Hurricanes Katrina and Rita incorporates a highly functioning and sustainable health infrastructure that is capable of providing high quality care, in the right setting, when needed by the population. The Department developed this vision with extensive input from local stakeholders. The principles for achieving that vision include:

- **Assist Locally Private Sector Efforts/Coordinate between Local, State and Federal Governments**

The Gulf's health infrastructure of delivery systems, staffing, and access to care needed by its citizenry, has evolved in ways unique to the culture and history of each community affected by Katrina and Rita. Over the past few months, local and state officials, providers, and other stakeholders have formed several planning coalitions expressing various visions and early ideas for how to rebuild the Gulf States with a new healthier future.

The role of the Federal government should be to support these existing mechanisms, offering expertise, when needed or desired, and taking action wherever possible to eliminate unnecessary impediments to rebuilding health infrastructure. Aid should be delivered, to the maximum extent possible, through existing State and local governments, rather than through the creation of new Federal institutions or programs. Successful solutions will be based on locally-led and community-based collaborative efforts.

The Federal Government has many significant programs that pay for care provided to individuals who evacuated because of the hurricanes. Other existing Federal Government programs support rebuilding the healthcare infrastructure. Individuals and entities should consider how these existing programs, described briefly in Attachment 2, may assist in the rebuilding efforts.

- **Support Ambulatory and Community-Based Services:**

Much of today's health care in the Gulf States relies on hospitals and other types of institutional care, e.g., nursing homes, psychiatric facilities, and large developmental centers. These large, multi-purpose facilities fill the unique purpose of assuring that delivery of emergency and acute care, or the most specialized interventions needed by the population can be made available on a 24/7 basis. In the absence of well developed regional or local ambulatory systems, these institutions also serve as the safety net in their respective communities which makes this lower level of care far more expensive to deliver than if it were provided in the home or on an outpatient basis.

Expense is only one aspect. Individuals who receive primary care through hospitals and other large institutions are subject to conditions that do not facilitate the most effective follow through of treatment for routine or chronic health problems. By necessity, the time available to do such treatments competes with time needed to do more imminent, acute interventions. This often results in long waits for patients, and ultimately the primary care they receive tends to be

piecemeal, impersonal, and lacking in the attention needed to educate and counsel them 1:1 on their conditions.

Before Katrina, access to primary care practitioners (family practice, general practice, internal medicine, pediatrics, and obstetrics/gynecology) already posed a significant problem in the delivery of health care in Louisiana. As of January 2003, the Bureau of Health Professions, National Center for Health Workforce Analysis recognized 68 primary care shortage areas in 55 parishes within LA. In addition, the Bureau identified shortages for physician assistants, nurse practitioners, certified nurse midwives, registered nurses, dentists, dental hygienists, psychologists, and social workers. The Federal role should be to assist communities in developing comprehensive community-based care incentives and strategies that target the demographic group expected to repopulate the area. The Department supports strategies that strive to rebalance care toward ambulatory and community-based services rather than emergency rooms and institutionally based care, while providing efficient, effective care delivery for all residents in the affected areas.

To avoid merely investing in the rebuilding of ineffective services and systems destroyed by Hurricanes Katrina and Rita, the Department's approach encourages the development of a transformed health care system characterized by consumer and family-driven services that are evidence-based, prevention-oriented, and leverage health care technology to assist providers in delivering state-of-the-art services while improving quality.

For example, there is good evidence that by anticipating patient needs, especially in those patients with chronic diseases, health care teams that partner with patients and coordinate across physicians can help implement physicians' plans of care effectively, reducing the need for expensive procedures and hospitalizations for preventable complications. Electronic record systems, emails, telemedicine, and other innovative approaches can help patients not only avoid costly complications, but perhaps even avoid the need for some office visits.

- **Provide Higher Quality Care and Preventive Services**:

Many hurricane evacuees suffer from chronic medical conditions. Yet they received treatment for those conditions in the most expensive manner possible: by relying on care in hospital emergency departments where care was sporadic, often inefficient, and where results were not monitored. This "system" of care delivery is ineffective. In 2002, for example, Louisiana ranked 50th (the least healthy State in the nation)[1], and its health status was 23.9% below the national average , with scores near the bottom in 15 of 17 measures used to rank the States, including infant mortality, (ranking of 49th) and premature death (ranking of 49th). Racial disparities with regard to health access and outcomes were also listed as another major contributor.

As the health care infrastructure in the affected States is rebuilt, HHS should lend its support to efforts that make that system more prevention oriented, advance the quality and value of health care, cultivate promising, evidence-based patient care improvements, and reward quality

[1] America's Health: United Health Foundation State Health Rankings, 2002.

outcomes. This type of continuous quality management will offer the best possible return on investment for all parties involved.

In many respects, HHS is moving toward a system that rewards providers for quality care. Through its nursing home and home health quality initiatives, HHS makes quality information from those providers publicly available to interested parties. The MMA also contained a provision that rewards hospitals for providing quality information to the Medicare program; 99% of the hospitals in the country are participating. CMS has also developed demonstration projects that reward hospitals for providing superior quality. These initiatives could be continued and enhanced in the affected States.

- **Support Integrated Efforts to Improve Quality**:

As transformation of the system achieves better balance, and incentives become aligned around quality, more efficiency and higher quality can be achieved by embracing use of electronic health technology. A paperless, fully interoperative, HIPAA-compliant system of medical records is the goal toward which HHS and all providers in the affected States should be striving. To date, each State and local coalition planning for recovery of the healthcare sector has recognized that interdependence within the new system cannot be achieved without developing such a system of health records. Agreement on the critical paths can lead to improved treatment protocols, reduction of medical errors and waste, and more comprehensive data to inform decision making. This will only enhance efforts to promote and provide higher quality care to residents. The Department should encourage local communities to improve the quality and safety of health services by greater reliance on and sharing of health information technology.

- **Support Personal Responsibility and Control:**

Self determination and personal responsibility is an American value embedded in all of the Department's patient rights and protections. The Department supports the self-determination of evacuees, since individuals and families focusing on their own needs, resources and interests are far more likely to reach and/or obtain favorable results for themselves and for the broader society than when government restricts or directs their choices.

Individuals need support to make such decisions, especially if those decisions carry greater amounts of risk to their health or security. To help people take more control of their health care, including greater emphasis on prevention, getting the services they prefer in their communities, and having access to simple yet comprehensive information to help them make the most prudent decisions possible, new initiatives should pay particular attention to supporting individuals directly, rather than institutions. All of the most-affected States were interested in taking steps in this direction prior to Hurricane Katrina.

For example, last July the State of Louisiana applied for a Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver that would provide incentives for enrollment of non-categorically eligible Medicaid beneficiaries into private health insurance plans rather than State-

run Medicaid programs. If successful, this will help further decrease LA's uninsured population below 19.3%[2].

- **Encourage Emergency Preparedness:**

Even under the best of circumstances, emergency management is not a perfect science and there is potential risk for loss of life or liberty when necessary to achieve the common good. To mitigate this risk, all participants in the system need to learn from the lessons of what worked well, and what didn't as a result of Hurricanes Katrina and Rita, and subsequently be prepared to establish new contingencies. The availability of well trained providers, appropriately equipped and rehearsed to implement these procedures will not only assure quality, but mitigate the risk of the same or similar negative outcomes from re-occurring.

The Department supports incorporating into the health care delivery system an all hazards approach for effective emergency preparedness for hospitals and other health care providers. For example, it is important for the federal government to encourage hospital participation in the Biosense initiative in order to be able to track potential public health or bioterrorism events in a real-time basis.

[2] America's Health: United Health Foundation State Health Rankings, 2002.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Deputy Administrator
Baltimore, MD 21244-1850

FEB 3 2006

Dwayne A. Thomas, M.D.
Chief Executive Officer
Louisiana State University
Health Sciences Center
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Baton Rouge, LA 70809-2256

Dear Dr. Thomas:

Thank you for your letter to Secretary Leavitt regarding the Medical Center of Louisiana at New Orleans' (MCLNO) current operations and its long-term plans to rebuild and re-establish inpatient services following the damage caused by Hurricanes Katrina and Rita. Additionally, you requested an acknowledgment of MCLNO's continued eligibility to bill for outpatient and emergency services until the inpatient services are re-established.

With respect to your current operations, i.e., emergency services being provided in "Hall J" of the New Orleans Convention Center and Ambulatory/Outpatient services being provided at the Delgado Building, CMS has made a determination that MCLNO may continue to bill Medicare and Medicaid for these services, provided the operations continue to meet provider-based payment rules under Federal regulations at 42 CFR 413.65. We based our decision on the reports from both the State of Louisiana and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which conducted visits of both sites, and on JCAHO's continued accreditation of MCLNO. We will continue to coordinate with JCAHO and the Louisiana State Survey Agency to ensure that any additional necessary surveys and inspections are made as expeditiously as possible.

In regard to MCLNO's negotiations with Ochsner/Elmwood Medical Center to lease some facilities for a small, level-one trauma center and the negotiations with Touro to lease beds at St. Charles General Hospital, CMS is supportive of both plans and will work expeditiously with the Louisiana State Survey Agency and all hospitals to confirm that the facilities, once operational, conform to Medicare and Medicaid law and regulations.

For future operations, we will arrange a conference call promptly to facilitate the resolution of any potential issues. If you have any further questions in the meantime, please contact Lisa Deaton of the Louisiana State Survey Agency at (225) 342-0415, or Molly Crawshaw at CMS' Dallas Regional Office at (214) 767-2091.

Sincerely,

Leslie V. Norwalk